Title: Sexuality in the context of physical rehabilitation as perceived by occupational therapists

Running head: Sexuality in rehabilitation

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Implications for Rehabilitation

- Addressing sexuality lifestyle habits with their clients remains a challenge for occupational therapists working in outpatient physical disability rehabilitation.
- Several factors influence the practice of occupational therapists in the domain of sexuality, including occupational therapist’s intrinsic factors, their practice process, contextual factors and client-related factors.
- Improved interdisciplinary practice in sexuality is needed to ensure that sexuality is addressed and that there are referrals to the proper health professionals according to clients' needs.
- The availability of sexology resources is an important factor for occupational therapists addressing sexuality.

Title: SEXUALITY IN THE CONTEXT OF PHYSICAL REHABILITATION AS PERCEIVED BY OCCUPATIONAL THERAPISTS

Running head: Sexuality in rehabilitation

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Abstract

INTRODUCTION: One of the challenges for rehabilitation professionals is to discuss sexuality with their clients. The main objective of this study was to explore occupational therapists' perceptions of the factors that influence their practice regarding the domain of sexuality, as well as the prioritization of these factors and the exploration of their needs.

METHODS: Descriptive qualitative study who took place in Montreal, Canada. Two focus groups were realized with seven occupational therapists working in outpatient setting in two different rehabilitation centers for physical disabilities. The focus group guide was based on the *Theoretical Domains Framework* (TDF). The verbatims were coded using *QDA-Miner* software and analyzed according to the principles of the Framework approach.

RESULTS: The majority of participants were women (n=6/7). Three main themes to answer main objective emerged: (1) Occupational therapist's intrinsic factors such as professional identity and knowledge/skills; (2) Contextual and process factors of practice, including assessment/analysis and human resources; (3) Client factors such as identity factors and capabilities. Several influencing factors that have a significant impact on practice have been prioritized, for instance the perception of the skill level of occupational therapists, interdisciplinary collaboration, culture/language and openness of the client to the subject of sexuality. The needs related to the acquisition of knowledge/know-how, human resources and continuing education were raised by clinicians.

CONCLUSION: There is a need in developing training tools to support clinical practice and to overcome the many barriers encountered by occupational therapists regarding the domain of sexuality.

Keywords: disability, occupational therapy, practices, rehabilitation, sexuality, Canada.

Introduction

In recent years, several studies have addressed sexuality in adults with one or more physical disabilities showing that it is common for sexual issues to arise in this population. Indeed, a systematic literature review [1] on post-stroke sexual functioning found the existence of significant associations between stroke and male and female sexual dysfunction as well as desire/libido and sexual satisfaction. Another quantitative study [2] aiming to demonstrate the effects of stroke on sexual functioning of stroke patients (n=192) and their spouses (n=94) showed a decrease in all the measured sexual functions, i.e., libido, coital frequency, erectile and orgasmic ability, and vaginal lubrication, as well as in their sexual satisfaction compared to their situation before the stroke. Another study exploring the association between physical disability and sexuality with 1 196 participants that had varied physical disabilities (including spinal cord injury, cerebral palsy and acquired brain injury) showed that sexual satisfaction and frequency of sexual activities was lower in physically disabled participants compared to non-disabled people [3]. Thus, the presence of sexual issues related to a diagnosis of physical disability is frequent enough to be considered in rehabilitation.

There is a plurality of scientific literature that reports that sexuality is poorly addressed in the rehabilitation of clients with physical disability and this would be related to several complex issues such as sexual dysfunction or decline in their libido, sexual activity and sexual satisfaction. One of the major issues raised by recent literature is the difficulty for health professionals in rehabilitation settings - including occupational therapists - to discuss sexuality with their clients [4, 5, 6, 7, 8, 9, 10, 11]. Indeed, a majority of healthcare professionals do not systematically discuss sexuality with their clients with physical disabilities, even if they do recognize their sexual needs [4, 5, 8, 9, 10]. In this regard, a quantitative study [4] reported that the majority of health professionals (90%; n= 732/813) agreed that sexuality issues should be addressed with clients using a holistic vision of the person. However, an even higher proportion of health professionals (94%) said they were reluctant to discuss sexuality issues with their clients. There is therefore a marked gap between professional ideology and practice. Considering that most of the healthcare professionals could contribute to the improvement of participation in sexuality for people with physical disabilities, this gap between their perceptions and practices is even more alarming since it suggests that clinicians do not consider the interdisciplinary rehabilitation of sexual difficulties [8].

Sexuality is included into the interpersonal interactions and relationships chapter (d7) under intimate relationships (d770) of the International Classification of Functioning, Disability and Health (ICF) [12]. Intimate relationships are considered as activities that contribute to the person's participation. Also, sexual activities are defined as “engaging in activities that result in sexual satisfaction and/or meet relational or reproductive needs’’ according to American Occupational Therapy Association [13]. Considering that occupational therapists' primary means of intervention are activities to optimize their clients' participation, they should therefore address their clients' intimate relationships and sexuality independently of deficits related body functions and anatomical structures, and according to clients' priorities and the opportunities of the practice setting, in order to improve their clients' health and well-being. One of the reasons occupational therapists would continue not to address sexuality in their practice would be the fear of having to assess and intervene in this field without being sufficiently trained [7, 8, 14, 15] and thus feel at risk of potentially exceeding own limit of professional expertise. The results of a survey with 58 occupational therapists practicing in Ireland showed that although sexuality is part of the activities that should be addressed in assessments or interventions, occupational therapists only address it very briefly in their practice [6]. The qualitative study by Mc Grath and Lynch [16] on perceptions of practice regarding sexuality in the context of rehabilitation for seniors, also reached the same conclusions that occupational therapists (n=22) did not feel sufficiently prepared to intervene on the subject of sexuality.

Several factors influencing occupational therapy practice have already been identified in the literature to explain why they do not address sexuality in their practice. In regards to the skills of health professionals (including occupational therapists), four main factors have been identified in the literature: a lack of self-confidence and perceived competence in how to approach the topic of sexuality [4, 6, 8, 16], a lack of knowledge and training regarding sexuality [4, 5, 6, 8, 14, 15, 16], perception that sexuality is not relevant for people with physical disabilities [6, 17] and the personal attitudes of the clinicians [4, 6, 8]. In terms of identity factors; age, marital status, sexual experience and clients’ culture [6, 15, 16] could influence the practice. In regards to environmental factors including the context and process of practice, the presence of one versus many persons (e.g. group interventions), lack of clarity regarding professional roles, lack of time [4, 6] and prioritization of objectives by managers [16] are also considered to be influencing factors. Among all these factors, lack of training in the field of sexuality is the most frequently

identified influencing factor by health professionals, including occupational therapists [4, 5, 6, 8, 14, 15, 16]. Apart from this need for training, Hyland and Mc Grath [6] further suggested the need to have clear guidelines in referring patients to sexual health experts, including sexuality issues in the initial assessment, and having guidelines that clearly describe the roles and responsibilities of each profession with respect to sexuality.

Thus, it appears that several studies have raised the importance for health professionals to discuss sexuality with adults that have physical disabilities. Among health professionals, it appears that occupational therapists would be very well suited to address sexuality as it is included as one component of relationships of the ICF and is thus defined as an activity/participation. These studies also identified several factors that contribute to the difficulty for clinicians in addressing sexuality in their practice. However, none of these studies focused on prioritizing influencing factors according to their degree of importance in a rehabilitation context. This may explain why most of studies on the subject refer mainly to the resolution of only one need, that is additional training for occupational therapists. But is additional training the only solutions and if so, what do they need to be trained for? Considering that occupational therapists' struggles in addressing sexuality seem to be related to more complex origins that would need a multicomponent approach, the prioritization of the factors that mainly influence practices in sexuality may lead to a better understanding of the situation and to design more efficient solutions.

The main objective of this study is therefore to explore occupational therapists' perception of the current influencing factors of their practice - in an outpatient physical disability rehabilitation context - in relation to the domain of sexuality. More specifically, we aimed to explore occupational therapists' perceptions of the predominant influencing factors and to explore their needs in order to address the identified influencing factors.

Methods

Focus Group Discussion

Information from this qualitative study who took place in Montreal, Canada was collected through two focus groups [18] conducted by an occupational therapy professional master's student and co-facilitated by an experienced occupational therapist currently doing a master's thesis on the topic of sexuality post-stroke. The focus group guide was developed in relation to the state of knowledge and the research objective. It was also based on the Theoretical Domains

Framework (TDF) which was initially developed to identify the factors that influence the behaviour of health professionals [19]. The 12 areas of influence of the TDF [20] served both in the development of the questions and as a background for discussion in the focus groups. Six open-ended questions were developed, ranging from more general to more specific subjects [21]. The topics related to the six main questions were as follows: (1) the role and responsibilities of the occupational therapist with respect to sexuality; (2) the place that sexuality occupies in the practice of occupational therapists; (3) the factors that influence the practice of occupational therapists with respect to sexuality; (4) the barriers and facilitators perceived by occupational therapists to address sexuality; (5) the predominant influencing factors; (6) specific needs to further address sexuality in clinical practice. Therefore, the first 4 questions were used as a guide to foster discussion to answer the main objective and thus described the perceptions of occupational therapists in relation to the reality of their profession and factors influencing their practice in sexuality. These factors were then prioritized through a discussion and consensus building in the 5th question. The 6th question focused on the perceived needs to deal with these factors.

Participants and Recruitment Procedure

Occupational therapists working in a physical disability outpatient rehabilitation service were targeted. These settings have been favoured since the subject of sexuality is addressed more often by these occupational therapists than those working in acute care or in-patient physical rehabilitation [22] where clients generally focus more on survival and improving basic physical functioning such as walking [23]. A sample size of 6 to 8 occupational therapists was targeted. Recruitment was carried out in two rehabilitation centres offering rehabilitation to an adult clientele. Participants had to have been working as occupational therapists for more than a year in one of the two targeted rehabilitation centres. A diversity in terms of years of experience and type of clientele was encouraged in order to have a global overall picture of occupational therapists' practice with regard to sexuality and also considering our explanatory qualitative design. The recruitment procedure allowed participants to provide free and informed consent as well as guaranteed confidentiality. Ethics approval was obtained from the Research Ethics Board of the targeted rehabilitation centres before recruitment was initiated.

Data Collection

The discussions were recorded in audio and transcribed as verbatim for analysis.

Sociodemographic (gender, age group) and data related to the context of practice (level of training, clientele served and number of years of experience) were collected through a short questionnaire in order to accurately describe the sample.

Data Analysis

Sociodemographic and data related to the context of practice were analyzed using descriptive statistics (frequencies and proportions) to describe the sample. The principles of the Framework Approach [24] were used to guide the deductive analysis (according to conceptual frameworks) of the data collected through the focus groups. The interdisciplinary Human Development Model - Disability Creation Process (HDM-DCP2) [25] and the TDF have guided the creation of codes that are associated with units of meaning (i.e. words, sentences, and paragraphs that grouped an idea). All units of meaning were coded (by first author) using the QDA-Miner analysis software using the participants' vocabulary. The code matrix was reviewed by an experienced researcher (last author) and an occupational therapist/master's student in sexual rehabilitation science (co-author). An analysis of the codes was realised according to the 5th question of the interview guide in order to bring to light the most influencing factors. Each code was then grouped into broader categories associated with the HDM-DCP2 model (personal factors, environmental factors and life habits) as well as with the TDF. Other categories were created to let the data speak for itself when the pre-selected models were not suitable. Similar categories have been brought together to form themes. In order to stimulate reflection, links were made and criticized between codes, categories and themes.

Results

The sample consisted of seven participants, divided into two focus groups. Participants worked in the following programs with some clinicians working in more than one program: Chronic pain (n=2); Amputees and severe orthopaedic injuries (n=1); Progressive diseases (n=1); Neuromuscular diseases (n=1); Neuro-musculoskeletal diseases (n=2); Traumatic brain injury (n=1). The majority of participants were women (n=6/7). The age and number of years of experience of the participants were varied (see Table 1).

(Insert Table 1 approximately here)

What factors are perceived to influence the practice of occupational therapists in sexuality?

The factors perceived as influencing the practice of occupational therapists were divided into three main themes (see Table 2): (1) Occupational therapist’s intrinsic factors including

categories related to the occupational therapist's professional identity, skills, knowledge, emotions and values; (2) Contextual and practice process factors including categories related to the mandate, follow-up format, conceptual model used, evaluation/analysis, agreement on objectives and planning and human resources in the environment; (3) Client's factors including categories related to client's identity factors and capabilities.

(Insert Table 2 approximately here)

What are the influencing factors perceived to have the greatest impact on the practice of occupational therapists in sexuality?

The following results are presented in descending order of importance under each of the three main themes (see Table 2). The main **occupational therapist's intrinsic factors** are grouped into three categories. The **ability to bring up the subject of sexuality** (1) positively influenced occupational therapists' practice with regard to sexuality, despite that difficulties were also reported to bring up the subject of sexuality. Several indirect methods were raised by clinicians to facilitate discussions about sexuality, such as explaining to clients that it is common to observe consequences on sexuality linked with a diagnosis or medication. The **perception of the skill level** (2) as a predominant factor of influence led occupational therapists to recognize their limitations in relation to their clinical skills in sexuality and to refer to other health professionals as needed. In fact, when occupational therapists felt that the issues raised by their clients were psychosocial or medical, they tended to give them a referral to see a sex therapist or a doctor. **Knowledge** (3) of the different means of intervention, such as positioning, energy conservation, planning and task simplification, was frequently mentioned by participants as contributing to positively influence their sexuality practice. However, several gaps in their sexuality training raised a sense of not being well trained and comfortable with the application of sexuality interventions in daily practice.

The main **contextual and process factors of the practice** were divided into five categories. **Sexology resources** (1), if available, positively influenced the practice. However, **interdisciplinary collaboration and communication** (2) were percieved as a negative influencing factor, as they were mostly ineffective at dealing with the subject of sexuality: "*Nobody takes it on themselves, because everyone thinks there's probably someone on the team who will do it, but obviously there's no one who does it"* [P3]. The use of an **initial assessment report template with a sexuality section** (3) was a predominantly positive influencing factor,

acting as a reminder to assess clients' sexuality habits. A **team of supportive and proactive occupational therapists** (4) was most often mentioned as a positive influencing factor either to validate or exchange information with colleagues or to identify sexuality intervention tools related to specific diagnosis. The **presence of another person/group intervention** (5) was most often mentioned as a barrier to discussing sexuality with clients.

Finally, **clients' factors** were divided into six categories**.** Identity factors such as a **culture/language** (1) that was different from the occupational therapist, complex **psychosocial factors** and **mental health comorbidities** (2) and sexuality not being considered a **priority for the client** (3) were factors negatively influencing the occupational therapist's practice in sexuality. On the other hand, the client's **personality and openness to the subject** (4) was a positive factor in ensuring that sexuality was integrated into occupational therapy follow-up. The following excerpt summarizes the influencing factors related to client identity mentioned above: "*The client's openness will be my main facilitator, but the complexity of the client's psychosocial situation, background or behaviour, or even the cultural barrier will tip it in the other direction*"[P4]. Deficits in the client's capabilities regarding **cognitive function** (5) were considered to be negative factors influencing practice. That is because the occupational therapist feels more limited in regards to what intervention to offer will have identified other priorities on which to work with a client with cognitive deficits: *Well, it's very limited what we can do about sexuality and there's so many other subjects to cover that we do not necessarily cover sexuality"*[P7]. Deficits in the client's capabilities regarding **inhibition ability** (6) was perceived to be related to a discomfort in discussing sexuality and a fear of having to constantly refocus an uninhibited client: *"I choose not to talk about sexuality because I really have the feeling that it will get out of hand"* [P3].

In summary, clinicians mentioned several factors already in place that positively influence their practice in sexuality, such as the ability of the clinician to bring up the subject of sexuality through backdoor methods, to acquire basic knowledge on the means of intervention possible, to get direct access to sexology resources, to use an initial assessment report template including a sexuality section, to have a team of proactive occupational therapists, as well as to have a clients that are open to cover the subject of sexuality. On the other hand, several factors that negatively influenced their practice in sexuality were also mentioned, such as a lack of training in sexuality, a lack of interdisciplinary collaboration and communication on the subject of sexuality, the

presence of a third party during the consultation, as well as several client-related factors such as a cultural and language barrier, complex psychosocial factors and mental health comorbidities, sexuality being a non-priority topic for the client, as well as cognitive deficits and significant uninhibited behaviors. Occupational therapists mentioned knowing how to recognize their limits in terms of their competence and how to give referrals when needed. This last factor was raised several times without the clinicians specifying whether it positively or negatively influenced their practice.

What are the needs of occupational therapists to address these identified influencing factors as potentially modifiable?

Four main themes emerged from the data analysis in relation to identifying the needs that occupational therapists could be fulfilled by addressing the influencing factors identified as potentially modifiable: (a) knowledge; (b) know-how; (c) human resources and (d) continuing education, as a mean to meet identified needs such as knowledge and know-how.

Knowledge

Participants who did not have sexology services available at their institution mentioned a need to better **understand the roles and limitations of other professionals** working in sexuality. Firstly, in order to better collaborate on evaluations and interventions to help achieve the client's objectives: "*By collaborating more with a sexologist or a social worker or a psychologist we know exactly : OK, I can stop here, the person* [the professional] *will continue, will take the content and in such a way, bring him* or *her* [the patient] *towards this objective*"[P5]. Secondly, in order to refer to the right professional if necessary: "*It's a little hard to refer to sexologists when I don't really know what she* [the sexologist] *is doing exactly and how far she can go*"[P6]. Clinicians also mentioned a need to **be aware of the existence and to have access to sexuality assessment and intervention tools** in order to facilitate their practice process once they discussed sexuality with their clients: "*Once we talked about sexuality there, having the right tools*"[P7] and "*If we had some kind of guidelines, it would certainly help*. (...) *I'm really thinking ahead, but even if it means having educational capsules. Not everyone is equally comfortable talking about certain topics"*[P6].

Know-how

A need to **acquire skills for bringing up the subject of sexuality** and provide more fluid and adequate follow-up was mentioned by one participant: "*It seems to me that there is something to do there, to give us the tools to be more comfortable*"[P3] and *"How to formulate*

the question so that the person precisely opens up (...). If I feel comfortable introducing myself, and if I am confident with how I will formulate my question, then I will use it well [the question]"[P3]. Clinicians also mentioned a need to **improve and systematize communications within the interdisciplinary team regarding** clients' sexuality. On the one hand, in order not to duplicate the task of professionals to address the subject and potentially embarrass the client by repeatedly asking him the same question: "*Working in a concerted way and getting along well (...) "Sexuality! It's been four times you've asked me the question today"* [Participant speaking for a patient]*, it could be more "delicate" than asking about walking*"[P3]. On the other hand, to ensure that the subject is addressed, and that information is shared with members of the interdisciplinary team: "*A possible need to systematize communication within the treating team on this subject, I think it is obvious in all our teams*"[P4].

Human Resources

A need for **sexology resources**, particularly the access to a sexology consultant, was expressed by participants who did not have sexology services available at their centre in order to be able to learn about relevant interventions and/or the need to refer: "*That we have access to a sexology consultant, without the client necessarily seeing the person (the sexologist), but that we can ask questions when we need*"[P7] and "[the need] *to have resources. We might even already have sexologists in our institutions, and we don't know*"[P4]. A need for **resources for the lesbian, gay, bisexual, transexual and other groups (LGBT+) community** was mentioned by this same focus group: "*There are many resources that exist for heterosexual relationships, but when you run into a client... that is homosexual or who does not fit the typical client frame, well, then, it becomes very difficult to find resources that are valid*"[P5]. A need for **perineal rehabilitation** was identified in both groups in order to be able to offer this service to clients who present perineal pain to complete their rehabilitation: "*We have many cases of internal pain. So pain during penetration, for example. (...) We feel a little helpless about that, because then they have to go find help in the private sector (...). So it can be an obstacle, a resource barrier*"[P1] and *"We have physiotherapists here who are trying to get perineal physiotherapy here in the rehabilitation centre, but it's been years they have been waiting for this and then...*[Animator] It hasn't worked? [P6] *No. While this would be extremely relevant*"[P6].

Continuing Education

Clinicians also mentioned the need to access continuing education on the topic of sexuality: *"Because training could provide more information on how to assess it* [sexuality] *properly. You were talking about your tool, but it's specific to multiple sclerosis, is there one for chronic pain, are there any typical interventions?* "[P1] and "*If I had training that could help me get around these difficulties, I think it would help me to be a better therapist and to make sure that the issue is addressed, and that the person who has a problem is able to name it and take action*"[P3].

In summary, clinicians mentioned a desire to improve their knowledge and skills (know-how) in order to feel more comfortable and better equipped to assess and intervene with clients when sexuality issues fall within their expertise. When the limit of occupational therapists' competence is reached, a need to have access to several resources related to sexuality was raised in order to offer more complete rehabilitation to clients. Finally, the means mentioned in order to meet the knowledge and skills needs of clinicians were to have access to continuing education regarding the practice of occupational therapy in sexuality. Also, at the interdisciplinary level, the focus was to improve communication and collaboration between professionals in an interdisciplinary team to ensure that the subject of sexuality is adequately addressed.

Discussion

The purpose of this qualitative study was to explore the perception of occupational therapists about the factors influencing their practice in relation to sexuality in the outpatient physical disability rehabilitation setting where they work. The factors that were perceived as having the greatest impact on practice were grouped into three broad categories: occupational therapist's intrinsic factors, factors related to the context and process of the practice, and factors related to the characteristics of the client.

Occupational Therapist's Intrinsic Factors

Ability to bring up the subject of sexuality

Clinicians reported using many strategies to facilitate the discussions about sexuality. For example, by explaining to clients that it is common to observe consequences on sexuality linked with a diagnosis or medication, or by discussing relationships in general. Thus, when the occupational therapists felt the need to cover the subject of sexuality, they demonstrated good skills in discussing or introducing the subject of sexuality, which is an unexpected outcome of the

study. Indeed, previous studies have shown that the majority of occupational therapists were unable to discuss sexuality with their clients because they lacked the skills to overcome their discomfort in discussing this subject [7, 8, 14, 15, 16]. In our qualitative study, clinicians spent a considerable amount of time discussing these strategies during the focus groups and showed that they value how to approach the subject of sexuality. They also reported the need to enrich their skills to bring up the subject more directly and to be more comfortable to make a thorough assessment about sexuality. However, these latter results could be influenced by a possible bias in the selection of participants since they volunteered for our study about sexuality and may have been more interested or comfortable than some of their colleagues with the subject. On the other hand, if occupational therapists who are more likely to approach sexuality require more training on how to approach sexuality and how to assess it, we can expect that those with fewer skills will benefit as much if not more of such training, meaning that this training is relevant for the vast majority of occupational therapists.

The perception of the skill level

According to the participants, sexuality was considered as a life habit falling under the role of the occupational therapist who has the responsibility of minimally "opening the door" to give space and opportunity to clients to express themselves on the subject. A study of the experience of persons that sustained spinal cord injuries regarding sexuality suggests that the process of resuming sexuality is one of searching for meaning and that the occupational therapist's responsibility is to help clients develop a resilient sexual life [26]. In addition, the clinicians in our study considered that they were not the only health professionals who could intervene in the development of a satisfactory sexual life, perceiving limits to their competence and to the occupational therapist's field of practice. The occupational therapists in our study had some understanding of their professional contribution (e.g., introducing the subject, intervening on positioning or energy management) and their professional boundaries, but had difficulty identifying to which professional a referral should be made once their limit was reached. Surprisingly, no one mentioned their role in promoting sexual health to ensure safe sexual behaviour (e.g. protection, contraception), which has already been reported in the literature [27]. For example, the occupational therapist could intervene on the skills of a client with motor deficits to facilitate the use of condoms. Nevertheless, a need to refer to other professionals was clearly expressed by the clinicians in the study when the client's problem required psychosocial

or medical intervention. Therefore, participating occupational therapists definitely confirmed that they perceived having a role in addressing sexual issues with their clients, especially in the context of sensorimotor problems.

Knowledge

Clinicians have demonstrated a good knowledge of sexuality interventions that can be used in occupational therapy, with descriptions similar to those found in a previous study [28]. Means of intervention included positioning, energy management, planning and task simplification. Clinicians in our study added that they used pain management as a mean of intervention in relation to sexuality. However, they also pointed to a significant lack of education in their university cursus, referring to a lack of general knowledge about the practice of occupational therapy in sexuality, which was also raised in several studies [4, 5, 14, 16]. In addition, there was a lack of continued education opportunities on sexuality for occupational therapists according to our participants. Clinicians have identified the need to enrich their knowledge and develop their skills (know-how) in order to be better equipped to assess and intervene on the subject of sexuality. These needs are consistent with those mentioned in previous studies indicating that occupational therapists have a lack of sexuality training to adequately address sexuality issues [6, 8, 15].

Factors related to the context and practice process

What our study brings to the state of knowledge is the perceived importance of factors related to the context and process of practice. Although some of these factors have already been mentioned in previous studies such as clear lines of reference to sexuality experts, the importance of interdisciplinary collaboration, the inclusion of a question on sexuality in initial assessment frameworks, and the presence of another person/group intervention [6, 16], the results of our study show that these factors have been perceived as predominant and can be modified to improve the practice. To these factors, our study adds that having a proactive team of occupational therapists is a contributing factor to the inclusion of sexuality in clinical practice. Even though the mandate of the rehabilitation centre was raised as a factor, it was not raised as a major influencing one. Participants mentioned that the social integration mandate of their institutions and the opportunity for long-term follow-ups allowed them to better address all life habits, including sexuality.

Sexology resources

In the group where clinicians did not have sexology services available, some concerns were expressed about discussing sexuality for fear of not being equipped to address some of the clients' issues. Situations related to relationships, sexual relationships, body image, self-esteem or gender identity were identified as likely to exceed participants' skill levels. Occupational therapists in this same focus group also mentioned that they felt more helpless when they had to intervene about sexuality with clients in the LGBT+ community, nor did they feel sufficiently equipped to refer them to quality resources. In comparison, clinicians of the other group who had access to the services of a sexologist were much more confident in discussing and opening up to the issue of sexuality. In addition, both groups perceived a lack of resources to help clients with perineal pain, which specifically referred to the expertise of physiotherapists specializing in perineal and pelvic rehabilitation. The lack of resources appeared to lower the propensity in which occupational therapists addressed sexuality with their clients, especially with the ones with whom participants felt that the needs exceeded the resources they could offer. By having access to specialized resources, occupational therapists would surely be more comfortable to open the door and offer their services to at least partially meet the needs of their clients, knowing that they can give referrals to complementary specialties, thus better apply their holistic vision and client-centred practice [29].

Interdisciplinary collaboration and communication

Although our study indicated the importance of interdisciplinary collaboration as a facilitator, the lack of communication between members of the interdisciplinary team could make it more complex for practitioners to know if any of the team members had discussed sexuality with their clients. We can therefore see that communication is a bidirectional factor, good communication facilitating it but miscommunication complicating it. Thus, communication mechanisms must be optimized if occupational therapists want to approach sexuality, requiring changes not only in the practice of the occupational therapist but in the interdisciplinary practices (e.g. a section in the medical file of the client). It was also noted that there was a lack of knowledge of the role of each of the interdisciplinary team members, which contributed to the difficulty of occupational therapists in referring their clients to the adequate health professional. Therefore, guidelines that clearly describe the roles and responsibilities of each profession with

respect to sexuality would be a facilitator for occupational therapists, which was also raised in another study [6].

Initial assessment report template with a sexuality section

A positive and repeatedly raised influencing factor by the group without an in-house sexologist was the inclusion of sexuality domain in the initial assessment template. This strategy, which has already been implemented in one of the two rehabilitation center, acts as a reminder and encourages occupational therapists to talk to their clients about sexuality. However, the absence of this factor was rather mentioned elsewhere [6] as a need to be filled. The inclusion of a sexuality question in the initial assessment template would therefore be adopted by occupational therapists from different backgrounds and countries in order to approach sexuality more consistently.

Team of supportive and proactive occupational therapist

A proactive team of occupational therapists was mentioned as a positive influencing factor for the group without an in-house sexologist. Perhaps this factor was perceived as possibly filling a gap in sexology resources. Indeed, as these clinicians valued sexuality as a legitimate life habit, this team, supported by the institution's managers, initiated the creation of a working committee on sexuality to identify sexuality intervention tools related to specific diagnosis. Thus, the team's proactivity and the support of managers showed that they can compensate, at least partially, for the lack of a specialized sexuality resource.

Presence of another person/group intervention

The presence of another person such as a family member or translator, was a significant barrier for clinicians. This barrier was also revealed in a previous study, where 57% (33/58) of the occupational therapists considered the presence of a third party as a barrier to discussing the subject of sexuality with their clients [6]. Occupational therapists would therefore be significantly less likely to discuss the subject of sexuality in the context of not being alone with the client since it does not encourage confidences or exchanges, especially since some information may need to stay confidential.

Client-Related Factors

Client’s identity factors

All study participants mentioned several difficulties in addressing sexuality when the client was different from the occupational therapist in terms of identity factors (age, gender,

culture, language). This was also mentioned in a previous study indicating that occupational therapy students may be less confident in working with clients with different backgrounds or life experiences for fear of not providing optimal services to them [15]. The identity factor that caused the greatest reluctance to address the subject of sexuality is culture, which was one of the three main categories of barriers identified elsewhere [16]. Occupational therapists mentioned, among other things, a reluctance to discuss the subject when they suspected that sexuality was a taboo for a client originating from a different culture. Our study adds another potential barrier to existing literature, the possibility of a shock of values that would directly pose a dilemma between clinicians' personal and professional values. Recalling two separate cases, clinicians indicated that they were uncomfortable equipping their clients to continue having sex for fear that they would not consent. It should be noted that in both cases, clients perceived sexuality more as a duty than a source of satisfaction. These ethically challenging situations could then be analyzed using the Patient-Centered Care Ethics Analysis Model for Rehabilitation to make a decision [30]. Finally, complex psychosocial factors such as antecedents of abuse or complex and negative social situations (e.g., unhealthy couple dynamics), or mental health comorbidities were raised as identity factors causing difficulties in intervening on sexuality. Our results are consistent with previous studies that have shown that occupational therapists are more comfortable intervening on more technical aspects of sexual activity and sexuality, such as positioning or adaptations, rather than intervening on complex personal and emotional aspects [16, 28].

Client’s capabilities

Participants in our study indicated that they were more reluctant to discuss sexuality with clients with cognitive impairments, which was also raised in Hyland and McGrath's study [6], and disinhibition. Some occupational therapists would thus tend to prioritize other functional objectives rather than address sexuality in view of their clients' cognitive deficits. They may also be concerned about addressing the topic because of negative implications for the established therapeutic relationship, preferring to refrain from addressing the topic for fear that disinhibited clients may misinterpret these interventions as sexual advances. These client-related barriers confirm that there is a need to improve the knowledge and skills of occupational therapists about communication with clients with cognitive impairments to make them more comfortable talking about sexuality with them and knowing which health professionals to refer to depending on identity factors and client capabilities.

Strengths and limitations

This qualitative study documented many factors influencing the practice of occupational therapists in sexuality. The use of the focus group and open-ended questions gave participants the freedom to express what was relevant for them, which provided rich data. However, we acknowledge that prioritization of factors cannot be generalized given the qualitative design. Another phase could be to use a quantitative design to prioritize those factors amongst a larger sample. The two focus groups made in two distinct rehabilitation centres had similar characteristics in terms of mandate and mission (social integration) but were also different in terms of resources (access or not to a sexologist), which provided different perspectives on how occupational therapists approach and explore the subject of sexuality in one same large city. The use of theories (TDF and HDM-DCP2) provided a solid foundation and a global vision of the problem that allowed us to consider all the factors influencing the practice of occupational therapists in sexuality and which will facilitate the comparison of our results with other studies. However, our methods had some limitations that must be considered in interpreting the results. Firstly, since we used focus groups for data collection, it is likely that one or more dominant individuals within the groups did not allow certain opinions to be heard [31], despite the use of means during the focus groups such as giving the floor to quieter participants or to everyone around the table in order to avoid this disadvantage. Moreover, both of the focus group were co-animated and were composed of three and four participants, respectively, which made it easier to give a voice to all participants. Secondly, due to the voluntary participation in our study, clinicians probably had a positive bias towards the subject of sexuality and its inclusion in their practice, which may have influenced our results. People who are less comfortable with the subject of sexuality would probably have brought a different perspective. However, knowing the influencing factors raised in this study by occupational therapists whose sexuality is a topic of interest can be used to equip the community, adding, for example, new clinical means. These means, once in place, can be used by all occupational therapists. Finally, although this study probably did not reach data saturation, several influencing factors and similar needs were raised by both focus groups. Moreover, most of our data matched the results of past studies with bigger samples. Nevertheless, different influencing factors or needs could be raised in additional focus groups, especially if they were done in other contexts.

Conclusion

Our study showed that several factors influence the practice of occupational therapists regarding sexuality in the context of outpatient rehabilitation for physical disability. The main contribution of this study relates to the prioritization of influencing factors and the identification of occupational therapists' needs in terms of sexuality have led to the identification of changes necessary for practice that can now be implemented by interdisciplinary teams. The first step would be to improve communication between members of the interdisciplinary team to ensure that the subject of sexuality is minimally addressed. Then, knowledge sharing about the role and responsibilities of each member of the interdisciplinary team in sexual matters would allow clinicians to refer to the adequate professional depending on the targeted needs of clients. The lack of in-house sexology resources prevents occupational therapists from exploring the subject of sexuality with clients and prevents clients from receiving full rehabilitation. A need for resources in sexology and specific resources for the LGBT+ community, as well as access to perineal rehabilitation for clients, was raised. Client identity factors that are different from those of the occupational therapist would lead to greater discomfort when dealing with sexuality. A different culture would raise a greater reluctance on the part of occupational therapists to approach sexuality for fear of offending the client or having value conflicts with the client about sexuality. Complex psychosocial factors, mental health co-morbidities, cognitive impairments or inhibition inability of clients would also increase the reluctance of occupational therapists to discuss the subject. Clinicians mentioned a need to have better tools on the subject to improve their competence in approach, assessment and intervention by considering clients' identity factors and capabilities through continuing education.

The next step in this study would be on the one hand, to develop continuing education for the practice of occupational therapists in sexuality, based on the results of this research, considering several similarities with the results of previous research. This training would provide tools for occupational therapists on attitudes to adopt depending on clients' identity factors, as well as on sexuality assessments and interventions. A general sexuality practice guide for occupational therapists practicing with a physical disability could also help to better supervise their sexuality practice, as it has been done specifically for clients with neuromuscular disorders [32].

Declaration of interest

The authors report no declaration of interest.

Table 1. Socio-demographic characteristics of participants (n = 7)

ID	Age group (years)	Gender	Schooling	Experience (years)
P1	30 to 39	F	Mastery	5 to 9
P2	40 to 49	F	Bachelor's degree	20 or +
P3	40 to 49	M	Bachelor's degree	10 to 14
P4	30 to 39	F	Bachelor's degree	10 to 14
P5	29 or -	F	Mastery	4 or -
P6	29 or -	F	Mastery	5 to 9
P7	30 to 39	F	Bachelor's degree	10 to 14

Table 2. Factors perceived as influencing the practice of occupational therapists (n=7)

1. Occupational therapist's intrinsic factors

- **Professional Identity**

  - Role of the occupational therapist

[P1] *Because for me it's a life habit like any other and I think that if we didn't approach it, it would reflect a little discomfort and indeed the person would tell to self if the OT didn't approach me how do I approach him and who else can I approach.*
[P2] *But at least to open the door to leave a space for the client to talk about it, I think that would be minimal.*

  - Responsibility with other professionals

[P2] *I think it's a shared responsibility, but I consider that we would still have a responsibility to do so.*
[P3] *The fact that it's precisely a shared responsibility is easy to shovel it into your colleagues' backyards and avoid approaching it.*

  - Perception of occupational therapists' skill level *

[P3] *The men who dared to approach him were saying: "Ah I don't have a girlfriend". There is a problem with how to meet them and I put it in the category of self-esteem and body image, and I push them towards sex therapists and then they come back to see the OT*
[P6] *Most of the time, I think, it's more a question of: I was able to have a libido. And then you look through the list of medications, you realize, you take 35 different kinds of medications. Maybe go back to your doctor or pharmacist to see if there is an impact.*
[P7] *We had clients who were disinhibited, and we referred this client, I have one in mind, to a sex therapist because it was beyond what we could do*

with him.

- **Occupational therapists' skills to bring up the subject of sexuality (know-how)***

[P1] *I'm talking about the fact that people in chronic pain use a lot of medication that can affect, for example, libido, the desire to be in a relationship, and now it seems as if it makes the person a little disempowered if there is a problem at this level.*
[P2] *I don't always know how to make the client feel 100% comfortable, to open the door and feel comfortable opening or closing it* […] *When they talk about how they are worried about their relationship, well, I manage to reopen that life habit there.*
[P3] *Sometimes it's just a matter of habit and including it in your little starter kit.*

- **Knowledge of occupational therapists***

[P5] *It took me a while to be able to talk about it more, because we hadn't really discussed this subject at the University.*
[P6] *I get into the subject and think to myself: will I be able to answer all his questions? (…) I mean, we haven't had specific course on sexuality and there's not much continuing education on sexuality.*

  - Intervention

[P2] *In terms of occupational schedule, to see if in terms of energy management if there was a time in the day when they are less in pain for example. That it might be a better time to have intimate moments.*
[P4] *But once again as I tell you about technical aids, I don't know them that well, but if the client comes to me with something and asks me for my opinion, well I'll analyse the activity, the tool and I'll say well…that's it, I'm an OT so I'm able to put one and one together and give my opinion.*

- **Emotions of occupational therapists (life skills)**

[P1] *I can't say that I feel perfectly comfortable asking the question. When I know the question is coming, I start preparing myself.*
[P2] *It's not talking about sexuality that intimidates me, it's imposing it on my client. That's what makes me uncomfortable.*

- **Occupational therapists' values**

[P3] *I try to give it the most importance because it was neglected before.*
[P7] *To be able to share this with the client sometimes the first meetings is not always easy. So I need to talk to myself.*

2. Contextual and Process Factors of Practice

- **Mandate in a rehabilitation centre**

[P1] *Maybe in home care it was less applicable, the mandate was different.*
[P4] *We are more focused on reintegration; we talk about the last life habits to be addressed. So it is the best place to cover the subject of sexuality.*

- **Using a model (Disability Creation Process-DCP)**

[P1] *I do it a lot at the end of life habits precisely in the interpersonal relations section and as we use the HDM-DCP2 I almost systematically apply it.*

- **Monitoring format**

[P5] *In the barriers, with the group approach it would be the therapeutic relationship. We don't have a strong enough therapeutic relationship, I barely knew the person, I didn't have such an individual relationship with the person. I will probably not approach it, or I will approach it with more distance.*

- **Evaluate/analyse**
  - Evaluation report template with sexuality*

[P5] *I found it easy to have it in the questionnaire, because some clients told me: it took a load off my mind that you asked me the question.*
[P7] *It's in the canvas, are we always doing it? No.*

- Choosing the right moment and time availability

[P1] *So here* [rehabilitation centre] *we see them for a long time. And sometimes we approach it in evaluation, but it is at the end of interventions, when the bond of trust is established that the person brings us back: ah you told me that… That there would be a possibility of….*
[P7] *Sometimes we know it, but sometimes we don't know how clients will react. And do we think now is the right time? I ask myself many more questions than in relation to other categories of life habits that we do like, OK, we go through the list.*

- Presence of another person/group intervention*

[P2] *Especially with the presence of parents during these exchanges with the young person. This is a barrier, this information is super confidential. So, it is not a situation that will encourage confidences and openness, an exchange on the subject.*
[P3] *Sometimes it goes without saying. Especially there, adults in relationships and spouses are present and some people talk about it openly. Well, that's easy. But all other contexts can be difficult.*
[P6] *I can't see myself talking about this subject with a translator. And often the translator will be a member of the family. That's a big barrier too. The discomfort is even more there.*

- **Agreeing on objectives/ and plan**

[P7] *Another thing that is difficult is that sometimes sexuality is not necessarily the priority for either the client or us. (…) And then, oops, sexuality, you realize that we put it aside and we come back to it, not always.*

- **Human Resources**
  - Interdisciplinary collaboration and communication*

[P3] *Nobody takes it on themselves, because everyone thinks there's probably someone on the team who will do it, but obviously there's no one who does it.*
[P7] *So when we talk about it, he's clearly a facilitator, everyone is open, but we don't do it much, so that's more of an obstacle.*

- Including sexuality objectives in interdisciplinary intervention plans

[P2] *There we raised the fact that there is a difficulty in the intervention plans; that there is a trace of that, but without it being too compromising for the client and also the concern that several health fields feel involved. So I sat down with the sex therapist to try to brainstorm and come up with examples of interdisciplinary goals that could be included in the intervention plan. It helped me in my practice to be able to go and get a grip on this kind of list of goals.*
[P7] *I find that it is left aside sometimes when it is not in the team's priority objectives or in OT or whatever.*

- Team of occupational therapists*

[P6] *After that, we created the sexuality committee where we were 3 OTs working on it. We pulled up a sexuality binder we had originally. We had researched to find all kinds of adaptations and made a kind of document depending on the diagnosis or the problem, what to do as an intervention, the more occupational therapeutic solutions.*
[P7] *The major facilitator is that we talk about it a lot in OT, that I think is the most important thing.*

- Management team

[P4] *One facilitating point was the training. It was initiated by the management to offer us this training. So whether you want to or not, there was still an interest on the part of the managers so that we could invest time, to adjust our interventions accordingly, so that we could integrate all this.*
[P6] *It's not just at our level it's even at an administrative level that she said to herself, let's see how the rehabilitation centre will give this to its clients, sexual postures with titles that are too explicit, in brackets, according to her judgment. It's just to say that the subject is not just taboo for us, but also higher up, at the management level. There they said to themselves: "the image of the rehabilitation centre, oh my God".*

- Sexology resources*

[P1] *I find it reassuring to have the sex therapist at the end who is the professional of this because I find our interventions more indirect.*
[P3] *Our clients are fortunate to have access to a sex therapist. It helps a lot to open the question, and to just start going on the subject.*
[P7] *When there are questions and we don't have the answers, well we're like, ah OK, I will refer you, I'll find out if I can find where to refer him, but there are not many resources.*

- Paying clients

[P6] *You have a client on insurances. Technically, it could probably cover a sexology session. But, does your client really want you to disclose that he has sexual problems to his insurances' rehabilitation counsellor?.*

3. Client-Related Factors

- **Client identity factors**

  - Culture/Language*

[P2*] Because we are indeed touching a lot the notion of consent and now we are thinking wow, I am giving tools to my client to feel less pain, so I am focusing on that, but it is not an area in which we are comfortable as individuals. Because she is making it clear to us in covered up language that her husband did not have her consent, but that it is her duty to do so. So that's it, there are many cultural communities for which that's the situation.*
[P6] *Our clientele is very, very multiethnic. Not even French or English speaking. So that, I would say that it's a challenge. I find it challenging to discuss sexuality with these clients because some of them are very, very reserved. And that for example, you may know it's a problem, but it's completely taboo, so you can't even address it.*

  - Gender and age

[P1] *It's more difficult sometimes when it's a man. As I am a woman sometimes it is easier to approach it with a woman.*
[P3] *It's to approach this in a context where sexuality among 80-years-olds is a taboo subject. So that too, same as for the cultural aspect, that too is a question of how to approach that with another generation, so as not to offend the person.*

- Personality/openness to the subject*

[P4] *As long as the client talks openly about it, shows openness and interest in the subject, I find it much easier to set the stage.*

- Sexual experience and celibacy

[P3] *There is precisely a premorbid and the person has a more exhaustive sexual experience than others for whom it is more in the making. That's where it's really hard. And also the perception that the person who is not in a relationship does not have a sex life. That too is a barrier in itself.*

- Psychosocial factors and co-morbidity in mental health*

[P1] *Sometimes, the information we don't have, but we can suspect, is all the trauma of childhood, abuse, etc. When you know there's a big antecedent, it gets all the time, I think it's tricky after that to approach it.*
[P6] "*f I have an extremely complex client, with a lot of psychosocial factors, a lot of mental health co-morbidities, I think that's going to be the barrier. Because you already know right away that you're going to have so many other problems, that you don't even see where you could go about this subject, and that you don't even want to talk about it, to open it, because this client has a portrait, maybe such a complex life story, that you don't even want to open the door.*

- Client priorities*

[P2] *We often arrive in their lives at a stage where everything is turned upside down and they have to prioritize where they put their energy, what they want to work on, etc. So often right away, at least with my clients, it's often swept off the carpet.*

- **Client's capabilities**
  - Cognitive function*

[P7] *With traumatic brain injured clients, it is clear that a major obstacle is significant cognitive disorder. Memory problem or expression difficulties, not being able to explain, he has aphasia for example. Well, what we can do about sexuality is very limited in those cases and there are so many other issues to work on that we won't necessarily get into the subject of sexuality.*

  - Awareness of deficits

[P7] *So it is rare that we will go to the subject of sexuality at this level because if the person does not recognize his difficulties well he can not make changes, have compensatory strategies or technical aids or whatever.*

  - Inhibition capacity*

[P2] *Another barrier for me is the clients who have very disinhibited personality disorders. (…) I choose not to talk about sexuality because I really have the feeling that it will get out of hand.*

Legend: * Influencing factors perceived as having the greatest impact on the practice of occupational therapists in sexuality

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